MDR: M4-02-2649-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $2,129.82 for date of service 01/22/01.

   b. The request was received on 01/18/02.

II. EXHIBITS

1. Requestor, Exhibit 1:

   a. TWCC 60 and Letter Requesting Dispute Resolution dated 01/04/02
   b. HCFA(s)
   c. TWCC 62 form/Medical Audit dated 08/29/01
   d. EOB(s) from Other Providers
   e. Medical Records
   f. Pre-authorization dated 12/29/00
   g. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit 2:

   a. TWCC 60 and Response to a Request for Dispute Resolution 04/16/02
   b. HCFA(s)
   c. TWCC 62 form/Medical Audit dated 08/29/01
   d. Carrier's Methodology
   e. Medical Records
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. This case file does not contain a Notice of Medical Dispute. The case file includes the carrier's three day response dated 01/22/02. On 04/11/02, this MDRO contacted the carrier regarding the 14 day response. The carrier stated that they did not receive the provider's 14 day response for additional information. The case file received from Austin contains two copies of the provider's response. The response from the insurance carrier was received in the Division on 04/17/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: The requestor states in the correspondence dated 01/04/02 that, "It is… position that this facility correctly and appropriately coded and billed for the surgical procedure performed on…01/22/00. Each and every item and service necessary for this surgical procedure including pre-operative and post-operative care were documented thoroughly…The…argument violates TWCC Rule 133.1(a)(8) which clearly defines fair and reasonable as the lesser of usual and customary charges, MAR or negotiated contract. In this case no MAR or contract is applicable, therefore, usual and customary must be paid…Exhibit 'F' contains copies of EOB's provided by…which indicates that…reimbursement rate is wholly inappropriate."

2. Respondent: The respondent representative states in the correspondence dated 04/16/02 that, "It is the carrier's position that a) the disputed date of service is out of jurisdiction, b) the requester failed to produce any evidence that its billing for the disputed procedures is fair and reasonable; c) this carrie's [sic] payment is consistent with fair and reasonable criteria established in Section 413.011(b) of the Texas Labor Code; d) Medicare fair and reasonable reimbursement for similar or same facility services is below this carrier's, and e) , [sic] the Commission has concluded that charges cannot be validated as true indicators of the facility's cost…it is this carrier's position that no further reimbursement is due the requester."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 01/22/01.

2. The provider billed the carrier $2,527.62 for date of service, 01/22/01.

3. The carrier paid the provider $397.80 for date of service, 01/22/01.

4. The amount in dispute is $2,129.82.

5. The carrier denied additional payment by denial codes, "M – THE REIMBURSEMENT FOR THE SERVICE RENDERED HAS BEEN DETERMINED TO BE FAIR AND REASONABLE BASED ON BILLING AND PAYMENT RESEARCH AND IS IN ACCORDANCE WITH LABOR CODE 413.011(B)" and "No additional payment is being made as the payment already made by the…has been determined to be fair and reasonable based on statistical studies of national data performed by the…The…fair and reasonable payment has also been made in accordance with the Texas Workers' Compensation Act and Rules."

6. The services provided by the requestor include such items as anesthesia and lab services, pharmaceutical products, medical and surgical supplies, sterile supplies, and EKG.

7. In accordance with Rule 133.1 (a) (E) (16), the provider unbundled the billed charges by, "Submitting bills in a fragmented way, using separate billing codes for multiple treatments or services when there is a single billing code that includes all of the treatments or services that were billed separately, or fragmenting one treatment or service into its component parts and coding each component part as if it were a separate treatment or service."

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were rendered at an ambulatory surgical center. Commission Rule 134.401 (a) (4) states ASC(s) "…shall be reimbursed at a fair and reasonable rate…"

Texas Labor Code Section 413.011 (d) states, "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve medical cost control. The guidelines may not provide for payment of a fee in excess of the fees charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

Rule 133.307 (g) (3) (D) states, "if the dispute involves health care for which the Commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount is a fair and reasonable rate of reimbursement in accordance with § 133.1 of this title…and § 134.1 of this title…"

Commission Rule 133.304 (i) (1-4) requires the insurance company to "develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement;…explain and document the method it used to calculate the rate of pay, and apply this method consistently;…reference its method in the claim file; and…explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement" when the insurance carrier pays a health care provider for treatments or services for which the Commission has not established a maximum allowable reimbursement. The carrier submitted their methodology and though, the entire methodology may not necessarily be concurred with by the Medical Review Division, the requirements of the Rule have been met.

The Medical Fee Guidelines General Instructions (VI) discuss that if a MAR value has not been established for a CPT code, reimbursement shall be, "…at the fair and reasonable rate."

The provider submitted additional reimbursement data (EOBs from various carriers) in an attempt to demonstrate payments of fair and reasonable documentation for treatment of an injured individual of an equivalent standard of living in their geographical area. The provider's documentation failed to meet the criteria of 133.307 (g) (3) (D) by not providing information demonstrating or justifying that the payment being sought is fair and reasonable.

Because there is no current fee guideline for ASC(s), the Medical Review Division has to determine, based on both parties' submission of information, who has provided the more persuasive evidence. As the Requestor, the health care provider has the burden to prove that the fees paid were not fair and reasonable. In this case, the provider submitted EOB(s) from other carriers, but the documentation is insufficient to determine if the charge of the provider is fair and reasonable. The provider failed to meet the criteria of 413.011 (d) and 133.307 (g) (3) (D).

However, the Respondent provided their methodology, as required by Rule 133.304 (i), which is sufficient to establish the amount requested by the provider is not fair and reasonable. Therefore, No further reimbursement is recommended.

The above Findings and Decision are hereby issued this 23rd day of April 2002.

Donna M. Myers, B.S.
Medical Dispute Resolution Officer
Medical Review Division